APIAHF
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

2008-2012 POLICY AGENDA

OCTOBER 2008

The Asian & Pacific Islander American Health Forum **(APIAHF)** is a national advocacy organization dedicated to promoting policy, program, and research efforts to improve the health and well-being of Asian American, Native Hawaiian, and Pacific Islander (AA, NHPI) communities. The mission of APIAHF is to enable AAs and NHPIs to attain the highest possible level of health and well-being. It envisions a multicultural society where AA, NHPI communities are included and represented in health, political, social and economic areas, and where there is social justice for all.

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INTRODUCTION

The Asian and Pacific Islander American Health Forum (APIAHF) is excited to introduce our 2008 to 2012 policy agenda! APIAHF works to improve the health and well-being of Asian American, Native Hawaiian, and Pacific Islander communities through policy, programs, and research. With a philosophy of coalition-building and capacity-building in local communities, we work with community-based organizations, public health leaders, and policymakers to ensure that the specific needs of our communities are addressed at national, state, and local levels.

National Context

The past 10 years have generated both momentum and challenges in addressing Asian American, Native Hawaiian, and Pacific Islander health and well-being. Although there is growing recognition of cultural and linguistic competence as a critical element of quality health care, funding for these services remains limited. Promising models at the state and national levels illustrate that the challenges of collecting, analyzing, and reporting data for Asian Americans, Native Hawaiians, and Pacific Islanders can be overcome, but there remains an alarming lack of data and research on Asian American, Native Hawaiian, and Pacific Islander health.

Asian Americans, Native Hawaiians, and Pacific Islanders have been dedicated to building programs and systems and shaping policy. This has resulted in the growth of national- and community-based organizations, local and regional health coalitions, and leadership from diverse populations and regions. Unfortunately, our communities face widening disparities, tightening federal and state budgets, increased health care costs, and an erosion of civil rights and opportunity.

Our Policy Priorities

This agenda outlines our national policy priorities for 2008 to 2012, as part of an ambitious framework for change in policies, in systems, and in the fundamental ways that we address health for Asian American, Native Hawaiian, and Pacific Islander communities (APIAHF, *Blueprint*, 2008). From 2008 to 2012, we aim to address the following five policy priorities:

1. Expanding access to health care for uninsured and underinsured Asian Americans, Native Hawaiians, and Pacific Islanders;
2. Improving quality of health care by promoting cultural and linguistic competency;
3. Ensuring a diverse and culturally competent health care workforce;
4. Increasing research and improving data collection of health and health care needs of Asian Americans, Native Hawaiians, and Pacific Islanders; and
5. Increasing investment in community-based health promotion programs.

This work is only possible through the collective efforts of our communities, leaders, organizations, and partners. Moving forward, we continue to work with our Native Hawaiian and Pacific Islander partners to develop a health policy agenda that reflects their unique history, political status, and experiences. We welcome you to join our network to advance a movement for optimal health and well-being of Asian Americans, Native Hawaiians and Pacific Islanders!

1 Expanding access to health care for uninsured and underinsured Asian Americans, Native Hawaiians, and Pacific Islanders

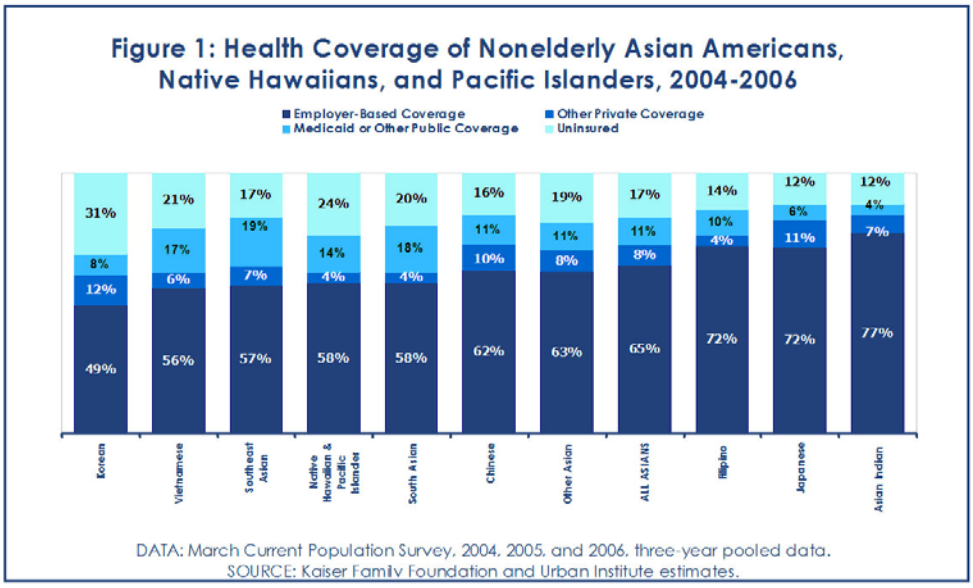
From 2006 to 2007, the number of people with health coverage grew for the first time since 2000.[1] Unfortunately, this was not true for Asian Americans who experienced a decrease in health coverage. What was also missing from this figure was the growing number of people, both with and without coverage, who struggle with rising health care costs, difficulties accessing care, or poor quality of care – problems which face a significant number of Asian Americans, Native Hawaiians, and Pacific Islanders. Unique factors make it difficult for Asian Americans, Native Hawaiians, and Pacific Islanders to access quality health care, such as: disparities in health coverage due to poverty; the significant percentage who work in or own small businesses; and barriers due to language and culture. As health care reform gains momentum, APIAHF will work hard to ensure that the various proposals include provisions that meet the needs of Asian Americans, Native Hawaiians, and Pacific Islanders by expanding health coverage, improving quality of care, and addressing health equity.

As a group, Asian Americans, Native Hawaiians, and Pacific Islanders are more likely to be uninsured than non-Hispanic whites. Specific groups face extremely high rates of uninsurance: From 2004 to 2006, 24% of Native Hawaiians and Pacific Islanders and 31% of Korean Americans were uninsured.[2]

The high rate of uninsurance in several Asian American communities correlates with their employment in or ownership of small businesses that do not offer health insurance benefits. For example, more than half of Korean Americans work in businesses with less than 25 employees. Yet, only half of employees in such firms receive coverage through their employer. As a result, Korean Americans have one of the lowest rates (49%) of employer-sponsored health coverage among Asian Americans, Native Hawaiians, and Pacific Islanders, compared to South Asians who have the highest rate at 75%.[3] By providing small businesses with affordable options, health care reform efforts could significantly lower the number of uninsured Asian Americans, Native Hawaiians, and Pacific Islanders.

Public programs such as Medicaid and the State Children's Health Insurance Program (SCHIP) also play an important role in reducing uninsurance in Asian American, Native Hawaiian, and Pacific Islander communities. Gains in coverage by these programs, between 1997 and 2004-2006, helped protect Asian Americans, Native Hawaiians, and Pacific Islanders from declines in job-based coverage. This helped decrease the number of uninsured Asian Americans, Native Hawaiians, and Pacific Islanders from 21% to 19% over that same period.[4] An expansion of public programs through health care reform efforts is critical for communities who cannot access affordable coverage through an employer or the private market.

Coverage of Asian Americans, Native Hawaiians, and Pacific Islanders in public programs grew in part due to federal and state efforts over the last decade to reduce barriers faced by minority and immigrant communities. However, many Asian Americans, Native Hawaiians, and Pacific Islanders that qualify for public programs remain uninsured because of language and cultural barriers in the enrollment process, misinformation about eligibility, and other family hardships such as food and housing insecurity. Others do not qualify even if they are low-income and legal immigrants. Since 1996, legal immigrants in low-income



families have been barred from receiving Medicaid or SCHIP during their first five years in this country, even when they meet all other requirements for the programs. Pacific Islanders' eligibility for public programs is dependent upon their immigration status as determined by their jurisdiction's compact with the U.S. or whether they are from a territory of the U.S. or a sovereign nation. For example, even though they may be allowed to work and travel in the U.S. for an indefinite period of time, most citizens of the Republic of the Marshall Islands (RMI), the Federated States of Micronesia (FSM), and the Republic of Palau are ineligible for public programs because they are considered under U.S. immigration policy to be non-immigrants.[5] Persons born in American Samoa and residents of the Northern Mariana Islands who did not elect to become U.S. citizens are considered U.S. nationals and are eligible for all federal benefits.

To address some of these barriers, many states developed strategies to help enroll individuals with limited English proficiency in Medicaid and SCHIP.[6] Some states also took steps to simplify enrollment and renewal procedures for children.[7] And, nearly half of states utilized state funds to continue covering legal immigrants during their first five years in the country.[8] Ensuring that similar solutions are enacted through health care reform would help eliminate the health insurance disparities faced by Asian American, Native Hawaiian, and Pacific Islander communities.

Although SCHIP reauthorization was unsuccessful in 2007, it presented an opportunity at the federal level to build upon the successful efforts of the program. Legislation would have increased funding to cover additional children, provided grants for outreach, strengthened benefits to include mental health and dental services, and implemented quality measures and reporting. APIAHF and its partners advocated for the reauthorization of SCHIP and continue to push for passage of the Immigrant Children's Health Insurance Act (ICHIA), which would remove the "five year bar" and allow lawfully residing pregnant immigrant women and immigrant children to access Medicaid or SCHIP during their first five years in the United States.

Until we guarantee affordable health coverage for all U.S. residents regardless of citizenship status, states could continue to enact incremental improvements that expand coverage to uninsured populations. Unfortunately, they face restrictive federal

policies that threaten to reverse the progress they have made. For example, New York, the home of the second largest Asian American population in the U.S., is one of fourteen states to adopt presumptive eligibility, a policy that allows schools, clinics, hospitals, and other qualified entities to preliminarily enroll a child who appears to be eligible so that the child can receive care that is covered while awaiting a final eligibility determination.[9] State efforts to facilitate enrollment for uninsured children, however, are hindered by the citizenship documentation provisions enacted in the Deficit Reduction Act of 2005, which require an original birth certificate, passport, or other similarly restrictive documents, as proof of coverage at the time of enrollment and renewal for Medicaid. According to officials in 37 states, this requirement has resulted in the first drop in Medicaid enrollment in a decade.[10] The vast majority of those affected are U.S. citizens, most likely those living in rural areas, persons with disabilities or African American.[11]

States have also expanded Medicaid eligibility as well as coverage of uninsured adults. For example, in New Jersey, the home of the third largest South Asian population in the country, eligibility under the SCHIP program was increased to 350% of the federal poverty level, while coverage was expanded for parents. However, a policy issued by the Centers for Medicare and Medicaid Services (CMS) in August 2007 imposes requirements that effectively bar states from enrolling children in families with incomes above 250% of poverty. As one of 22 states impacted by this new policy, New Jersey would have to cut back or delay their efforts.[12] As states struggle under new restrictive policies, a declining economy, and the rising cost of health care, the number of uninsured Asian Americans, Native Hawaiians, and Pacific Islanders will likely grow unless there is action at the federal level to implement health care reform.

ACTION

EXPANDING ACCESS TO HEALTH CARE FOR UNINSURED AND UNDERINSURED ASIAN AMERICANS, NATIVE HAWAIIANS, AND PACIFIC ISLANDERS

→ Champion universal health coverage that meets the needs of Asian Americans, Native Hawaiians, and Pacific Islanders.

→ Support the reauthorization of SCHIP with the following provisions: full funding to cover all eligible children, and outreach and education targeted to immigrant communities, utilizing community health workers and language interpretation and translation services.

→ Eliminate barriers to enrollment by repealing the proof of citizenship requirements in the Deficit Reduction Act of 2005; supporting the passage of the Legal Immigrant Child Health Improvement Act (ICHIA); and removing limitations in current law that disqualify citizens of the Republic of the Marshall Islands (RMI), the Federated States of Micronesia (FSM), and the Republic of Palau, from eligibility for Medicaid, SCHIP, and other public benefit programs.

APIAHF sets forth the following principles to guide our advocacy on health care reform:

- Affordable health coverage should be available to all individuals regardless of nativity or citizenship status.
- Health coverage should offer comprehensive benefits that include oral, mental, and substance abuse coverage.
- Any reform that is employer-based must include affordable options for small business employers and self-employed individuals.
- Systems of accountability should be designed and implemented to monitor and track coverage and access to healthcare by Asian American, Native Hawaiian, and Pacific Islander ethnic subgroups.
- Health care should be linguistically and culturally appropriate, accounting for the vast ethnic and linguistic diversity among Asian Americans, Native Hawaiians, and Pacific Islanders.
- The healthcare workforce should reflect the ethnic diversity among Asian Americans, Native Hawaiians, and Pacific Islanders.
- Health coverage and health systems should support evidence-based complementary alternative medicine.
- Health coverage and health systems should promote prevention and primary care across the lifespan.

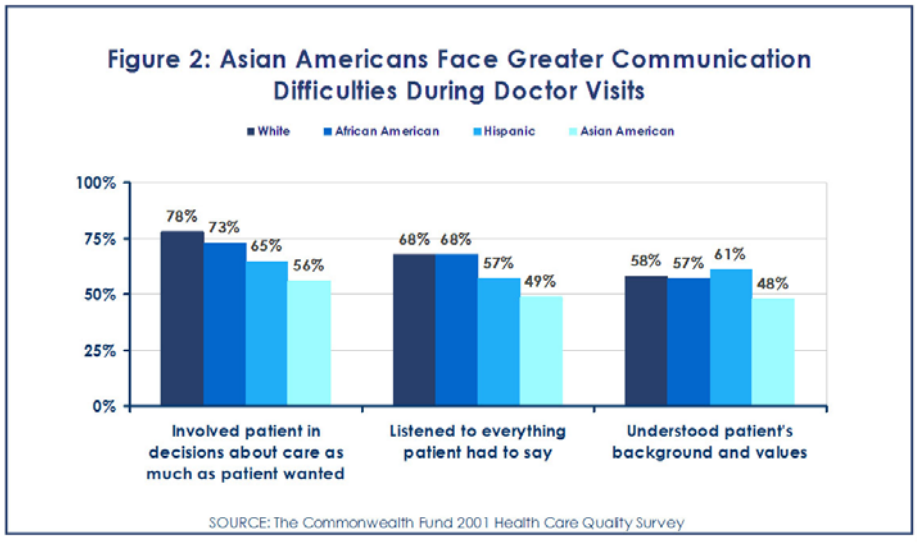
2 Improving quality of health care by promoting cultural and linguistic competency

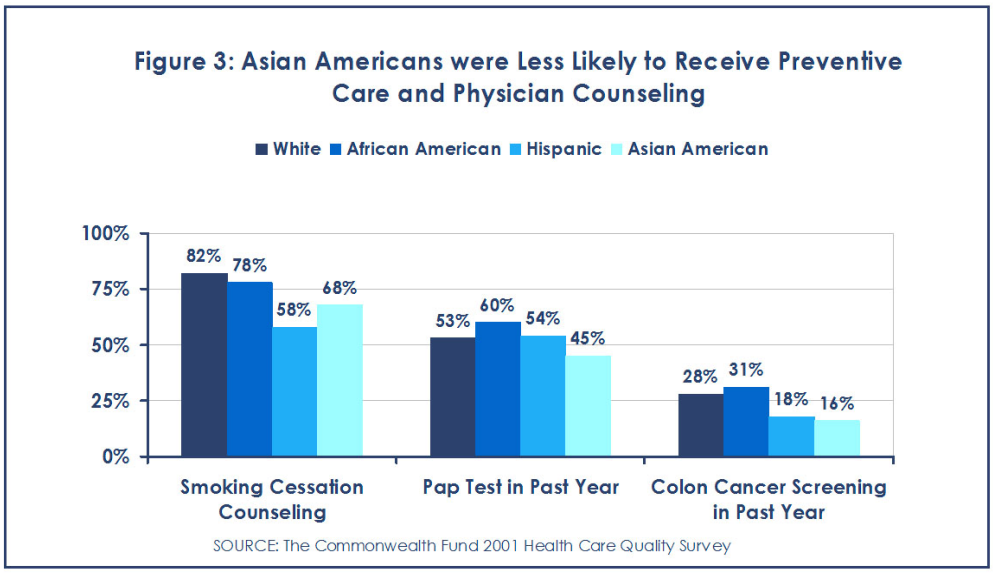
In 2001, the Institute of Medicine (IOM) highlighted serious concerns with the quality of health care in the U.S. Too often, health care falls short on important principles, such as safety, effectiveness, timeliness, efficiency, equity, and patient-centeredness,[13] creating a gap between the care that we should receive and the care that is delivered today.

Unfortunately, the gap in quality of care is even greater for racial and ethnic minorities, including Asian Americans, Native Hawaiians, and Pacific Islanders who face cultural and language barriers when accessing health care.[14] Linking cultural and linguistic competence to efforts to improve the quality of health care would strengthen quality improvement programs and equip health care systems to respond to the unique needs of Asian American, Native Hawaiian, and Pacific Islander communities.

When health systems lack cultural and linguistic competence, they also fail to meet standards of quality care, leading to the delivery of lower quality care for Asian American, Native Hawaiian, and Pacific Islander communities.[15] Findings from the Commonwealth Fund's 2001 Health Care Quality Survey concluded that Asian Americans experience poor access to quality care on a range of measures."[16] Asian Americans reported greater communication difficulties and lower levels of satisfaction during their health care visits.[17] They were also "the least likely to feel that their doctor understands their background and values, to have confidence in their doctor, and to be as involved in decision-making as they would like to be."[18]

Despite having higher rates of certain health conditions, many Asian Americans, Native Hawaiians, and Pacific Islanders do not receive the recommended levels of prevention, counseling, or care they need. The 2001 and 2006 Health Care Quality Surveys revealed that Asian Americans were significantly less likely to receive preventive services such as cancer screenings and cholesterol checks, or counseling about smoking cessation, diet, weight, exercise, and mental health.[19] Less than half of Asian Americans with chronic conditions received the care they needed to manage their conditions.[20]





APIAHF will advocate to increase funding for health interpretation and translation services in health care settings. Individuals with limited English proficiency have the right to access government-funded health care regardless of their ability to speak English. Meaningful access is facilitated when language interpretation and translation services are provided throughout the health care system. Unfortunately, access is often denied and quality is compromised in too many cases because funding for such services is limited.

APIAHF will also advocate for the collection of data on race, ethnicity and primary language. This data would be useful in creating benchmarks for access, quality and accountability and would support the development of quality improvement efforts that address the health disparities faced by Asian Americans, Native Hawaiians, and Pacific Islanders.

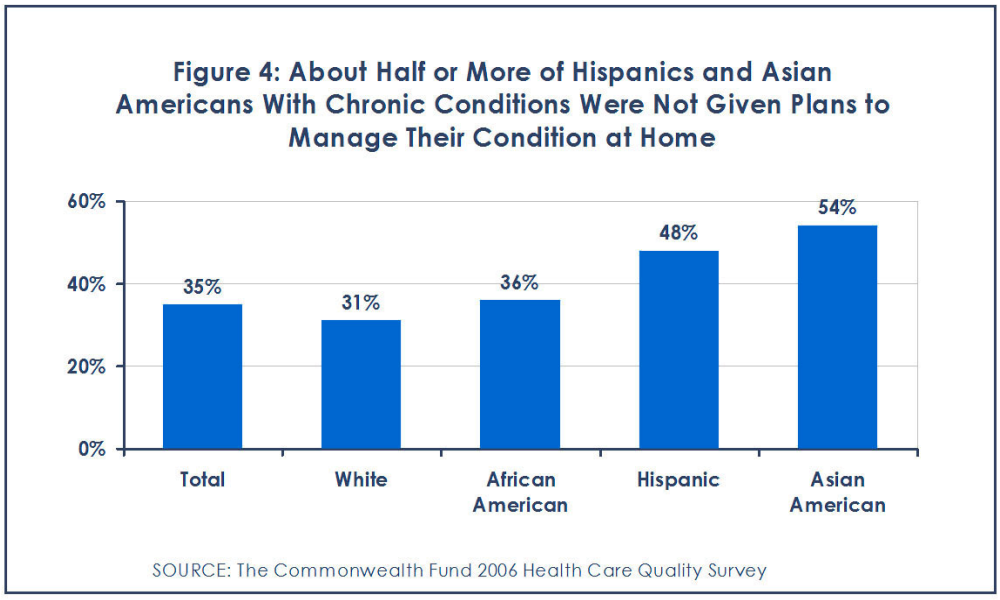
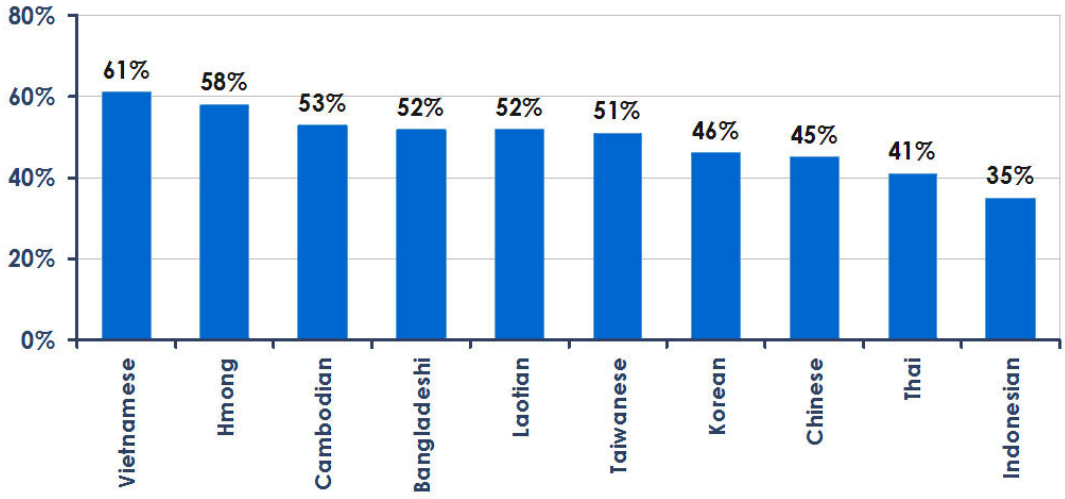


Figure 5: Limited English Proficiency Among Asian Americans



SOURCE: 2000 Census, Community of Contrasts, Asian American Justice Center

ACTION

IMPROVING QUALITY OF HEALTH CARE BY PROMOTING CULTURAL AND LINGUISTIC COMPETENCY

→ Increase funding and support for health interpretation and translation, including grants to improve access to language services for LEP individuals and federal reimbursement of language services through the Medicare, Medicaid and SCHIP programs.

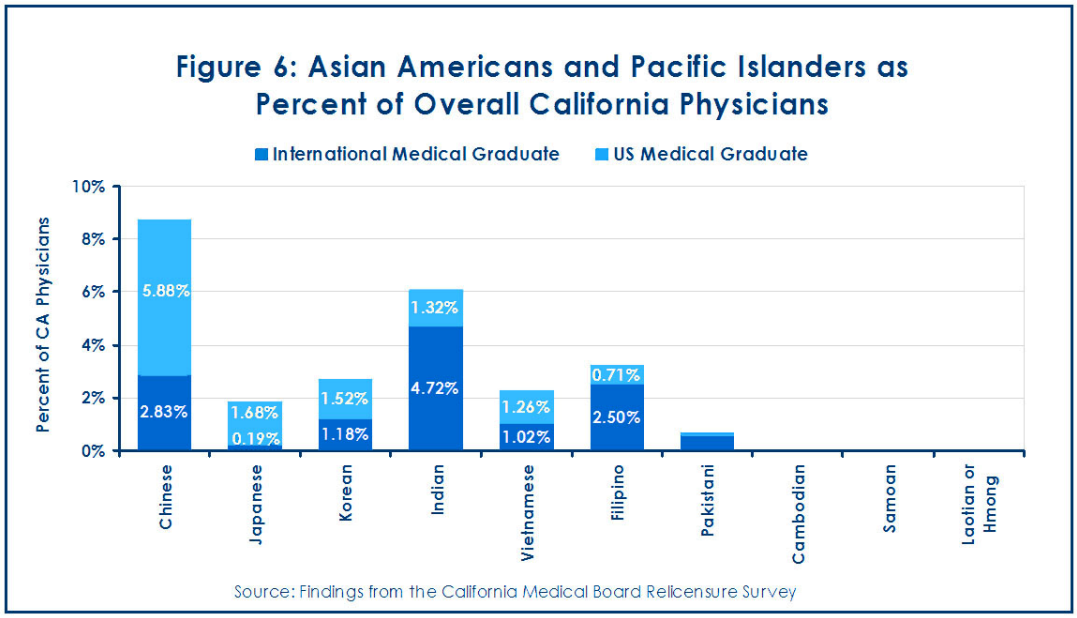
→ Support the collection of data on race, ethnicity, and primary language.

→ Support efforts to link cultural and linguistic competence to quality improvement initiatives.

3 Ensuring a diverse and culturally competent health care workforce

A diverse healthcare workforce is critical to improving access to quality care, access to culturally and linguistically appropriate care, and patient choice and satisfaction for minority, Asian American, Native Hawaiian, and Pacific Islander communities.

Although statistics suggest that Asian Americans as a whole are well-represented among physicians, a comprehensive look at the healthcare workforce reveals that many groups are poorly represented.[21] For example, findings from a survey conducted by the California Medical Board indicate that there are shortages of many Asian American and Pacific Islander subgroups in California's physician workforce. Less than 0.05% of California's physicians, or an estimated 90 of the 61,861 physicians in the state, were Cambodian, Laotian, Hmong, or Samoan.[22] In 2005, the Association of American Medical Colleges reported 3,111 Asian American medical school graduates nationally compared to 45 Native Hawaiian or Pacific Islander medical school graduates.[23]



Even less progress has been made in reporting data on the diversity of Asian Americans, Native Hawaiians, and Pacific Islanders in other health professions, such as nursing, dentistry, and allied health, which include many frontline healthcare workers, such as community health workers, health educators, and outreach workers. This limited data suggests that Asian Americans, Native Hawaiians, and Pacific Islanders are underrepresented as nurses, psychologists, and health services researchers.[24]

Fortunately, academic institutions and state medical associations are taking steps to address the lack of data on Asian Americans, Native Hawaiians, and Pacific Islanders in health professions. The California Medical Association sponsored legislation, enacted in 2001, requiring the California Medical Board to survey physicians when they renew their licenses. Every two years, physicians are asked to identify their ethnicity from a list of 28 ethnicities, and to indicate if they speak any of 34 languages listed.[25] In 2007,

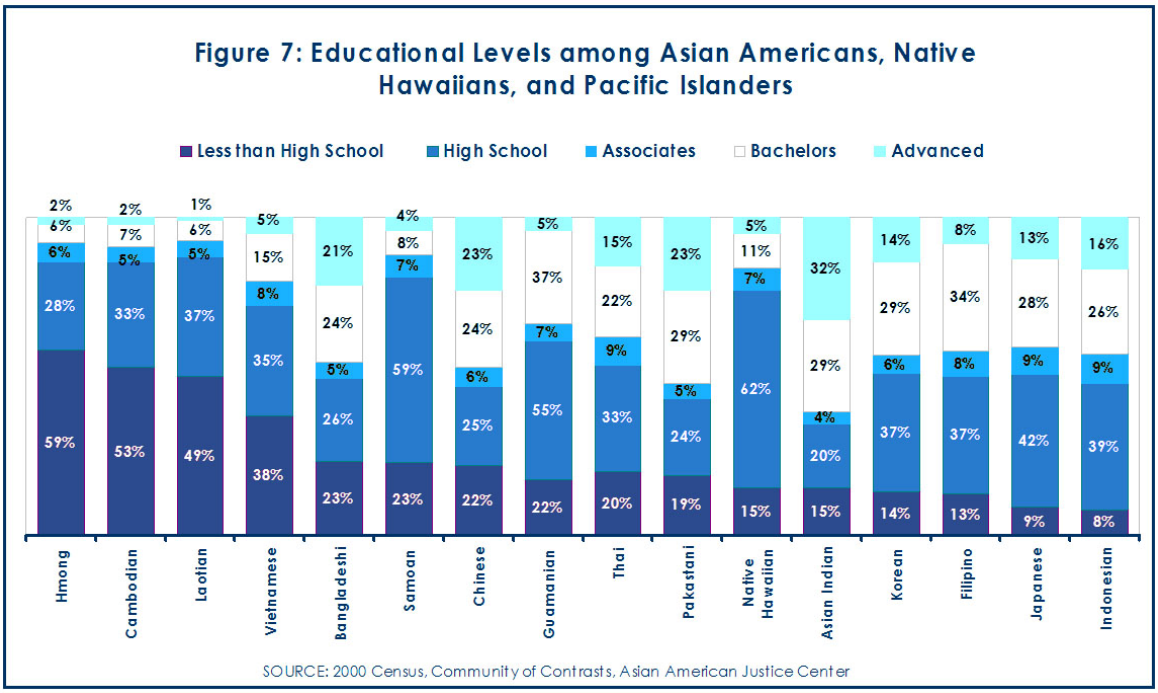
the University of California became the first public higher education institution to collect and report data on Asian American, Native Hawaiian, and Pacific Islander ethnic groups through its undergraduate application.[26]

The shortage of Asian Americans, Native Hawaiians, and Pacific Islanders in the health professions is a serious concern because many Asian American, Native Hawaiian, and Pacific Islander communities continue to be medically underserved, with little or no access to culturally and linguistically appropriate primary and mental health care, and because the needs of Asian Americans, Native Hawaiians, and Pacific Islanders are often not considered in broader health research agendas. The U.S. Surgeon General noted in 2001 that nearly half of Asian Americans, Native Hawaiians, and Pacific Islanders have problems accessing mental health services because of the lack of providers with appropriate language skills.[27] From 1986 to 2000, only 0.2% of health-related grants and 0.01% of Medline articles mentioned Asian Americans, Native Hawaiians, and Pacific Islanders.[28]

Efforts to increase the diversity of Asian Americans, Native Hawaiians, and Pacific Islanders in the healthcare workforce are also limited by the lack of a standard definition and process for determining underrepresentation in the various health professions.[29] Because public and private agencies and academic institutions use different definitions and this determination serves as the basis for allocating funds from numerous programs, Asian American, Native Hawaiian, and Pacific Islander communities are often excluded from programs that seek to increase diversity in the health professions. For example, the Health Resources and Services Administration (HRSA), within HHS, utilizes a definition of underrepresented minorities that includes Native Hawaiians and Pacific Islanders but excludes "Chinese, Filipino, Japanese, Korean, Asian Indian, Thai, and Vietnamese/Southeast Asians." APIAHF will advocate for a standard definition of "underrepresented minorities" that considers the inclusion of underrepresented Asian Americans, Native Hawaiians, and Pacific Islanders.

The shortage of Asian Americans, Native Hawaiians, and Pacific Islanders in health careers is also closely linked to the inequalities in educational opportunities that face many Asian American, Native Hawaiian, and Pacific Islander communities. Ten Asian American, Native Hawaiian, and Pacific Islander groups have lower than average rates of high school completion, and three groups have the lowest rates among racial and ethnic groups.[30] APIAHF is committed to protecting and increasing funding for programs that provide financial resources, such as scholarships and loan repayment, and to health professions pipelines for Asian Americans, Native Hawaiians, and Pacific Islanders who are underrepresented in the healthcare workforce.

APIAHF will also work to increase the availability and competency of health care interpreters and bilingual and bicultural health professionals. Strategies will include the recruitment and training of bilingual and bicultural members from underrepresented communities, the provision of ESL and job training, as well as changing health professions programs to include cross-cultural education and training on how to work with interpreters.



ACTION

ENSURING A DIVERSE AND CULTURALLY COMPETENT HEALTH CARE WORKFORCE

→ At the very minimum, disaggregate health professions data on Native Hawaiians and Pacific Islanders from data on Asian Americans.

→ Support the collection and analysis of health professions data by Asian American and Pacific Islander subgroups.

→ Adopt a standard definition of "underrepresented minorities" that considers the inclusion of specific Asian American and Pacific Islander subgroups that are underrepresented in specific health professions.

→ Reauthorize and increase funding for programs that support diversity in the healthcare workforce, such as the Health Careers Opportunity Program and the Program of Excellence in Health Professions Education for Underrepresented Minorities.

→ Support workforce development and training programs that increase the availability and competency of health care interpreters and bilingual and bicultural health professionals.

→ Develop and evaluate curricula in health professions programs that increase awareness of the impact of culture and language on health, health behaviors, diagnoses, and treatment.

4 Increasing research and improving data collection of health and health care needs of Asian Americans, Native Hawaiians, and Pacific Islanders

Twenty years after the dearth of Asian American, Native Hawaiian, and Pacific Islander health data spurred the founding of APIAHF there is still a need for more data. Important health and surveillance data on Asian Americans, Native Hawaiians, and Pacific Islanders continues to be collected and reported at the federal and state level as "Other/Unknown," or the data is not collected, reported, or analyzed at all.

This lack of data is a problem made more acute by the growth and diversification of Asian American, Native Hawaiian, and Pacific Islander communities over the last 20 years. It is still difficult to know the health status of specific Asian American, Native Hawaiian, and Pacific Islander ethnic groups such as Hmong, Laotians, Asian Indians or Micronesians. It is also difficult to disaggregate socioeconomic groups such as new immigrants or the poor.

Fortunately, promising models at the state and national level illustrate that the challenges of collecting, analyzing, and reporting data for Asian Americans, Native Hawaiians, and Pacific Islanders can be addressed. In 2000, the Census produced data on Native Hawaiians and Pacific Islanders for the first time. As federal and state agencies and health surveys continue to implement the Office of Management and Budget's Standards for the Classification of Federal Data on Race and Ethnicity, data on Native Hawaiians and Pacific Islanders will be separated from data on Asian Americans and gradually made more available. Achieving an accurate count of Asian American, Native Hawaiian, Pacific Islander, and other hard-to-reach communities through the 2010 Census and American Community Survey, however, will require a strong language assistance plan, and community partnership and outreach programs.

The successes of the National Latino and Asian American Study (NLAAS) and the California Health Interview Survey (CHIS) also demonstrate that it is possible to produce data on Asian American, Native Hawaiian, and Pacific Islander ethnic groups. By oversampling and interviewing specific ethnic groups in their own language, these studies overcame the methodological issues (e.g., small sample size, confidentiality concerns) that often prevent data on Asian Americans, Native Hawaiians, and Pacific Islanders from being analyzed or reported.

Lack of data, or methodological issues do not, however, completely explain the issue. Lack of resources is also a problem. Racial and ethnic communities rely on techniques such as oversampling, which are usually the first to face funding cuts. Adequate funding is also needed to analyze and disseminate findings on the data that already exists. For example, data on Asian American, Native Hawaiian, and Pacific Islander subgroups could be improved by combining data from several years, or bridging data from different surveys. To support these efforts, government agencies and research institutions should plan, prioritize, and collaborate with Asian American, Native Hawaiian, and Pacific Islander communities, and provide adequate funding and guidance to carry out these much needed techniques. Health plans, hospitals, and other providers can also play a unique role in collecting and reporting data on Asian American, Native Hawaiian, and Pacific Islander health status, health disparities, and the development of interventions.

Communities need relevant and accessible data and research to identify disparities, develop interventions and policies, and replicate the solutions that work. It is important for communities to have an equitable voice in research to ensure that the research is relevant, and that the design and content will meet the needs of those served. Community-based participatory research (CBPR) is a powerful strategy for promoting a community relevant and culturally appropriate approach to addressing health disparities and inequities. Despite its promise, however, CBPR is underresourced and underutilized.[31]

Clearly, more must be done to create an environment that supports Asian American, Native Hawaiian, and Pacific Islander research. At the 2006 Asian American and Pacific Islander Health Summit, APIAHF started the process of convening stakeholders to build consensus around a new agenda for change. APIAHF continued this process with a meeting in Washington, DC in April 2007 attended by key stakeholders from academia, think tanks, public health, policy organizations, and community-based organizations. In May 2008, APIAHF hosted its second annual Health Brain Trust to explore ways to increase the involvement of Asian American, Native Hawaiian, and Pacific Islander communities in CBPR. As a result of these meetings, we will outline concrete action steps from the participants' recommendations, publish several briefs, and establish a kitchen cabinet of advisors and allies who are both research savvy and policy savvy.

Figure 8: Improving Health Survey Data on Asian Americans, Native Hawaiians, and Pacific Islanders

	Current Population Survey	National Health Interview Survey	Medical Expenditure Survey	California Health Interview Survey
National Origin	✓	✓		✓
Immigration Status	✓	Partial	Partial	✓
Language Proficiency	✓	Partial	Partial	✓
Oversample of Asian Americans		✓	Partial	✓
Interview in Asian languages				✓

SOURCE: Presentation by Leighton Ku, PhD, MPH, during the Health Brain Trust on Data and Research, held from 4/29/07-5/1/07, in Washington, DC

ACTION

INCREASING RESEARCH AND IMPROVING DATA COLLECTION OF HEALTH AND HEALTH CARE NEEDS OF ASIAN AMERICANS, NATIVE HAWAIIANS, AND PACIFIC ISLANDERS

→ Protect and fully fund the National Center on Health Statistics and the U.S. Census Bureau and ensure that 2010 Census efforts include a strong language assistance plan and community partnership and outreach programs.

→ Work with federal and state agencies to enforce OMB's Standards on Collecting, Maintaining and Presenting Federal Data on Race and Ethnicity, and to improve their collection and reporting of Asian American, Native Hawaiian, and Pacific Islander data.

→ Establish a health survey with sufficient sample size to improve our understanding of the unmet health and health care needs of Native Hawaiians and Pacific Islanders.

→ Support planning, prioritization, and collaboration among government agencies, researchers, and Asian American, Native Hawaiian, and Pacific Islander community members to improve health surveys and initiate new research.

→ Strengthen the role of community-based organizations in community-based participatory research, as well as funding for this research.

5 Increasing investment in community-based health promotion programs

While improvements in health systems can lead to better care and outcomes, community-based programs also play a major role in promoting health and reducing health disparities. Many Asian American, Native Hawaiian, and Pacific Islander communities have successfully created model programs that provide health education, prevention, and quality care in limited English proficient, immigrant, and low-income communities.

Achieving health equity in Asian American, Native Hawaiian, and Pacific Islander communities begins with a focus on the underlying factors that lead to health disparities, such as poverty, the lack of culturally and linguistically competent services, and the lack of preventive health care. These factors, for example, are at the heart of the leading cause of death for Asian Americans – cancer.[32] Cancer deaths have increased at a faster rate among Asian Americans, Native Hawaiians, and Pacific Islanders than any other racial and ethnic population. Recent declines in death rates for breast and colorectal cancer have not been as large among Asian Americans, Native Hawaiians, and Pacific Islanders as among whites.[33] This is due in part to the relatively low screening rates and late stage diagnoses that occur among Asian Americans, Native Hawaiians, and Pacific Islanders. Fortunately, community-based programs are overcoming these barriers by promoting cancer education and screening with culturally-based approaches, linguistically appropriate materials, and attention to the factors that are needed to promote healthy communities such as access to safe, affordable physical activity and healthy, affordable foods.[34]

Promoting health in Asian American, Native Hawaiian, and Pacific Islander communities also requires broader strategies impacting multiple levels, including building support at the community level for improving health, and advocating for changes at systems and policy levels. Although 41% to 60% of Asian American women report experiencing domestic violence during their lifetime,[35] as few as 9% may obtain help from a service agency.[36] Programs serving battered Asian American, Native Hawaiian, and Pacific Islander women must engage in both prevention and advocacy that includes community organizing to change community norms that prevent battered women from seeking help and keep gender violence in place. At the same time, these programs must address barriers in multiple systems, including child welfare, housing, and law enforcement programs, to ensure the health and safety of battered Asian American, Native Hawaiian, and Pacific Islander women and their children, and their continued access to those programs.

In developing any health promotion program, it is important to partner with communities. For example, Asian American, Native Hawaiian, and Pacific Islander HIV/AIDS organizations prioritize basic community mobilization activities and leadership development so that Asian Americans, Native Hawaiians, and Pacific Islanders living with HIV/AIDS can be meaningfully involved in the development of prevention efforts. Capacity building efforts are also critical at the organizational level, particularly as organizations struggle to sustain themselves as the need for services increases and federal funding declines. Although Asian American, Native Hawaiian, and Pacific Islander communities account for 1% of AIDS cases in the United States, Asian Americans, Native Hawaiians, and Pacific Islanders experienced the highest percentage increase in HIV infection and

AIDS cases among racial and ethnic groups over the most recent four year period.

Expanding a number of heath improvement initiatives at the federal level would help make health equity, and optimal health and well-being, a reality in Asian American, Native Hawaiian, and Pacific Islander communities. These include: the Racial and Ethnic Approaches to Community Health (REACH) 2010 program, within the CDC; the Office of Minority Health, within HHS; the Minority Aids Initiative; and the Family Violence Prevention Services Act. Through their support of community-based health promotion programs that are culturally and linguistically appropriate, these programs help strengthen the capacity of minority community-based organizations and have had a significant impact on health disparities.

Federal recognition and support should also be used to expand promising strategies that have been adopted at the community level. Many Asian American, Native Hawaiian, and Pacific Islander communities utilize community health workers (CHWs) to bridge the gap between communities and health systems. As community members who work in community settings, CHWs are uniquely effective in expanding access to culturally and linguistically competent services and providing outreach, social support, health education, and prevention.[37]

Figure 9: Leading Causes of Death by Race/Ethnicity, 2003

ALL AGES					
Rank	**White**	**Hispanic**	**African American**	**Asian American & Pacific Islander**	**American Indian & Alaska Native**
1	Heart Disease	Heart Disease	Heart Disease	Cancer	Heart Disease
2	Cancer	Cancer	Cancer	Heart Disease	Cancer
3	CVD	Accidents	CVD	CVD	Accidents
4	Lung Disease	CVD	Diabetes	Accidents	Diabetes
5	Accidents	Diabetes	Accidents	Diabetes	Liver Disease
AGES 25 - 44					
1	Accidents	Accidents	Heart Disease	Cancer	Accidents
2	Cancer	Cancer	Accidents	Accidents	Heart Disease
3	Heart Disease	Homicide	Homicide	Heart Disease	Suicide
4	Suicide	Heart Disease	HIV	Suicide	Liver Disease
5	Liver Disease	HIV	Cancer	CVD	Cancer

Note: CVD=cerebrovascular disease.
Data: National Center for Health Statistics, National Vital Statistics System.
Source: Kaiser Family Foundation, *Key Facts on Race, Ethnicity and Medical Care*, January 2007.

Policymakers could increase the use of CHWs by recognizing their roles, skills, and contributions and providing support through stable funding, evaluation, technical assistance, and continuing education.[38]

Investing in resources and capacity at the community level enables communities to address their health needs and improve their surrounding social, economic, and physical environments for the future. Unfortunately, only 4% of health care spending is allocated for prevention and public health, while 96% is spent on medical care despite growing evidence that prevention programs and policies have a greater capacity to reduce the risks of illness and death and achieve cost savings.[39] In addition, Asian Americans, Native Hawaiians, and Pacific Islanders are among the communities that are least represented in efforts to reduce health disparities and promote health.[40] APIAHF will continue to advocate for resources to raise public awareness of Asian American, Native Hawaiian, and Pacific Islander health issues, to build the capacity of Asian American, Native Hawaiian, and Pacific Islander community-based organizations, and to inspire local, state and federal health institutions and policy makers to partner with these communities.

ACTION

INCREASING INVESTMENT IN COMMUNITY-BASED HEALTH PROMOTION PROGRAMS

→ Increase funding for the Office of Minority Health which conducts and supports health promotion and disease prevention programs that help reduce the high rates of death and disease in communities of color.

→ Support funds for outreach, including support for the Community Health Workers Act of 2007.

→ Codify and increase funding for the CDC's Racial and Ethnic Approaches to Community Health (REACH) program which supports communities in reducing disparities in health and healthcare.

→ Reauthorize and fully fund the Family Violence Prevention Services Act, whose grants help address the needs of underserved populations including underserved racial and ethnic minorities and those with limited English proficiency.

→ Fully fund the Ryan White HIV/AIDS Treatment and Modernization Act of 2006; the Minority AIDS Initiative; and interpretation and translation services for LEP persons living with HIV/AIDS.

→ Support investments in community-based organizations that address chronic disease prevention, interventions, treatment, and survivorship.

CONCLUSION

APIAHF will seek to effect these policy changes through policy and data analyses; building coalitions with Asian American, Native Hawaiian and Pacific Islander community-based organizations, community leaders, providers and researchers, minority and immigrant health advocates, and other health care and public health advocates; and engaging in legislative, administrative, private sector and media advocacy. We welcome you to join our network to advance a movement for optimal health and well-being of Asian Americans, Native Hawaiians and Pacific Islanders!

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